A rare case of keloidal granuloma faciale with extra-facial lesions

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ABSTRACT

Granuloma faciale (GF) is an uncommon, cutaneous disorder characterized by one to several soft, erythematous to livid papules, plaques, or nodules, usually occurring on the face. Extra-facial lesions occur rarely. We present a case report of 33-year-old male who presented with keloidal lesions on face and left shoulder. The patient didn't respond with intralesional triamcinolone and showed poor response with the addition of topical tacrolimus. Surgical excision in consultation with plastic surgeons is planned.

Key words: Extra-facial, granuloma faciale, keloidal

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INTRODUCTION

Granuloma faciale (GF) is an uncommon, benign chronic skin disease of unknown origin characterized by single or multiple, soft, erythematous to livid papules, plaques, or nodules usually occurring on the face, often with follicular accentuation and superficial telangiectasias.[1] The term granuloma faciale was first coined by Pinkus in 1952.[2]

GF is seen in adult males and females, with male preponderance.[3] Sites of predilection include nose, periauricular area, cheeks, forehead, eyelids, and ears. It was suggested that actinic damage plays a role in causing GF. However, GF is also reported to occur on extra-facial areas of the body, such as trunk and extremities.[4]

Our patient presented with facial and extra-facial lesions. Extra-facial or disseminated GF has been reported but is very rare.[5-8]

CASE REPORT

A 33-year-old male presented with multiple, reddish-brown plaques, and nodules involving the face for last 14 years. The lesions were insidious in onset, starting from the cheek, slowly increasing in size and number to involve forehead, nose, chin and had progressed to involve the left shoulder in last 1 year. The patient did not have any other complaints, except mild itching at times in the lesions. He did not give any history of trauma.

On examination, multiple, reddish-brown plaques and nodules, firm in consistency, were present on bilateral cheeks, forehead, nose, chin and left shoulder ranging in size from 0.5 x 0.5 cm to 2.5 x 2 cm. There was no systemic involvement [Figures 1 and 2]. The clinical differential diagnoses considered were keloid, lupus vulgaris, nodular sarcoidosis, cutaneous leishmaniasis, granuloma annulare, and erythema elevatum diutinum.

Biopsy was taken from the lesion on the forehead and shoulder and both showed similar histology. Biopsy showed a diffuse dense infiltrate in most of reticular dermis, mainly consisting of neutrophils and histiocytes, with scattered lymphocytes and occasional plasma cells. The infiltrate surrounded small thickened vessels and extended extensively into the interstitium, and small amount of nuclear dust also was seen. Overlying epidermis and dermo-epidermal junction was completely spared [Figures 3-5].

The above findings were consistent with a diagnosis of granuloma faciale. The patient received intralesional triamcinolone acetonide 40 mg/ml every 4 weeks for 6 months, but there was no response. The patient is currently on intralesional triamcinolone 40 mg/ml every

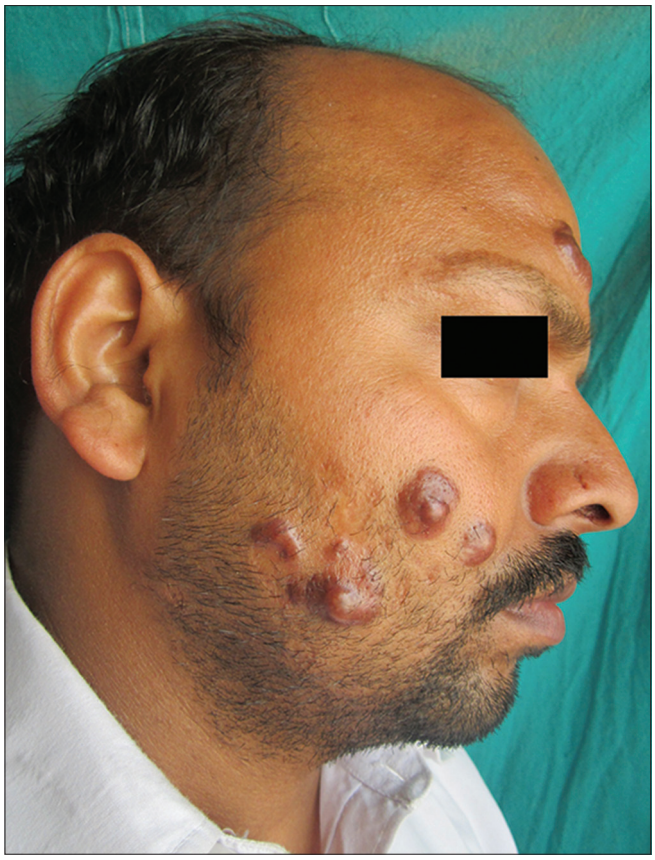

Figure 1: Clinical photograph showing keloidal lesions on cheeks

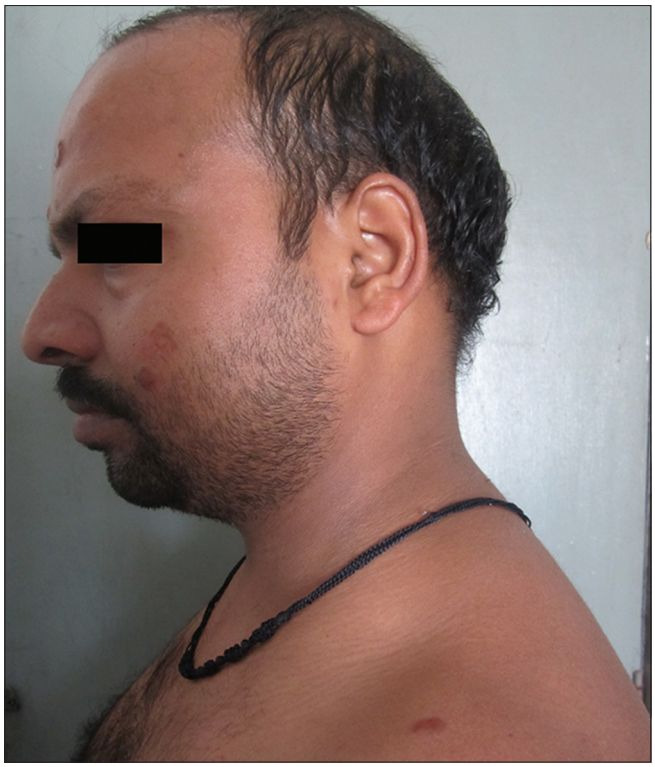

Figure 3: Clinical photograph showing facial and extra-facial lesions

4 weeks with topical tacrolimus. There is slight flattening of few lesions.

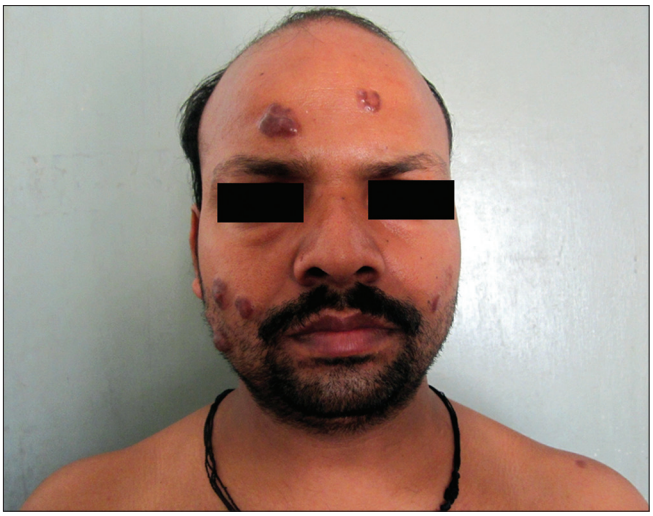

Figure 2: Clinical photograph showing lesions on face and left shoulder

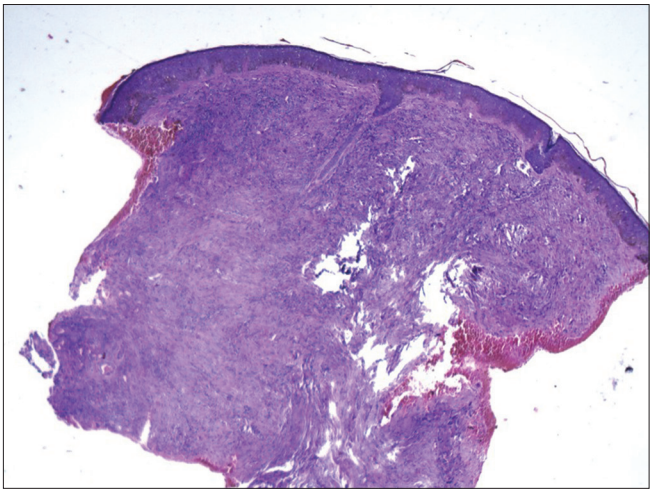

Figure 4: Histopathology; showing diffuse dense infiltrate involving reticular dermis which surrounds small thickened vessel, extends extensively into the interstitium with sparing of overlying epidermis and dermoepidermal junction. (H and E, ×100)

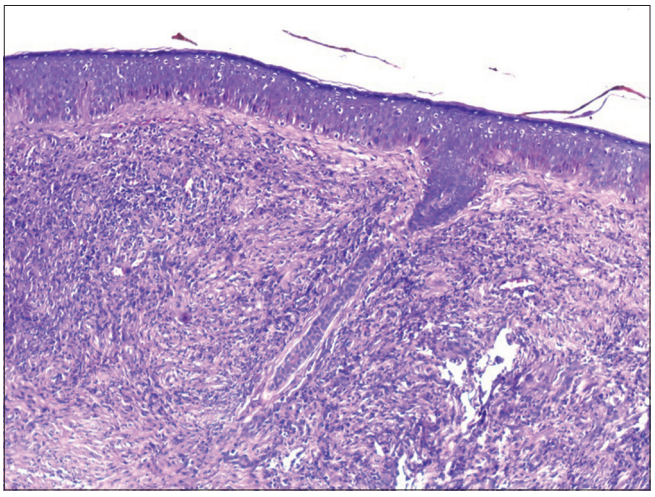

Figure 5: Histopathology; showing diffuse dense infiltrate involving reticular dermis, which surrounds small thickened vessel, extends extensively into the interstitium with sparing of overlying epidermis and dermoepidermal junction. (H and E, ×400)

DISCUSSION

The lesions of GF usually involve the nose, forehead, or cheeks.[2] Granuloma faciale is usually symptomless. Some patients may complain of tender itching or stinging lesions.[3] Extra-facial involvement is rare, and in our case, the keloidal nature of the lesions is still rarer.[5-8]

The skin is the primary organ system that is affected. The diagnosis of GF can be established by skin biopsy. The term granuloma in GF is a misnomer as granulomas are never present histologically. Diffuse dermal infiltration with neutrophils, lymphocytes, and eosinophils with sub-epidermal narrow Grenz zone is highly characteristic of granuloma faciale. There is usually an associated vasculitis.[4]

GF has to be differentiated from other conditions that have similar clinical appearance and/ or are characterized by vasculitis.[9] The clinical conditions to be differentiated include sarcoidosis, cutaneous lupus erythematosus, polymorphous light eruption, Jessner lymphocytic infiltration, lymphocytoma cutis, mycosis fungoides, insect bite reaction, and fixed-drug eruption. Though erythema elevatum diutinum is a chronic form of vasculitis, Grenz zone is characteristically not seen.[10]

GF is notoriously resistant to treatment. Many different medical therapies, including topical or intralesional corticosteroids, dapsone, antimalarials, isoniazid, clofazimine, and topical nitrogen mustard, have been tried with variable results. A variety of surgical procedures, like surgical excision, dermabrasion, argon laser, pulsed dye laser, carbon dioxide laser, electrosurgery, and cryotherapy have been used for the management of GF.[8] In our patient, there is poor response to intralesional corticosteroids, so we are planning surgical excision in consultation with plastic surgeons.

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